County of Ventura Plan for

In-Home Supportive Services (IHSS)

Fraud Prevention

Enclosure B

COUNTY RESPONSE COVER PAGE – MUST BE FULLY COMPLETED AND SUBMITTED WITH PLAN AND DATA

Ventura County is requesting participation in the Enhanced Anti-Fraud Program and will submit a Plan and Data as described above, by November 1, 2009.

Board of Supervisor Approval
Approved on October 27, **2009, by the County Board of Supervisors**
Name of Approver: Steve Bennett

Signature

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Brian Gonzalez will e-mail by Friday

LIST OF REQUIRED COUNTY PLAN COMPONENTS

IHSS Overpayments/Underpayments

The Welfare and Institutions Code 12305.8 (b) establishes the definition for In- Home Supportive Services (IHSS) overpayments. Overpayments in and of themselves are not fraud but are often the first indicator of fraudulent activity. As such, IHSS initiated the Fraud Prevention and Detection Work Group in April 2009 to identify gaps in its internal processes and to implement changes in how IHSS coordinates its activities within the Human Services Agency, with DHCS Services Fraud Investigation Unit and with the County of Ventura District Attorney Fraud Unit. The District Attorney's Office Fraud Investigation Unit provided valuable input into the process. As a result, the Human Services Agency (HSA) for the County of Ventura IHSS program designed and implemented an integrated approach within the agency to identify, prevent and detect overpayments and suspected fraudulent activity.

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An Integrated Approach

There are 4 units within HSA that work together to identify, track, monitor and recoup overpayments. These include:

- The IHSS Public Authority (PA)
- In Home Supportive Services (IHSS)
- IHSS Quality Assurance
- County Case Management Information and Payroll System (CMIPS) payroll

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Each of these units is essential in early identification of overpayments and work jointly within the Human Services Agency.

IHSS and/or Public Authority social workers are the first line of defense in identifying, preventing and detecting overpayments. Once an overpayment is identified, each completes the HSA IHSS Alleged Fraud/Overpayment Referral Form (County of Ventura form #56-13-4; see attached).

The referral and supporting documentation is reviewed by the IHSS/Public Authority management staff to ensure the accuracy of the information, which is entered into the IHSS Overpayment Tracking System, a data base designed to track and monitor overpayments. Certified letters are mailed to the identified provider/recipient notifying them of an overpayment and the reason for the overpayment. This letter requests a review of the overpayment by the provider or recipient with a plan for repayment within 10 days. A key element of the letter is the notification that failure to respond in a timely manner, initiates a referral to the DHCS Investigative Unit. The Welfare and

Institutions Code Sections12305.83 (1) provides the authority for IHSS to take all appropriate action to recover the full amount of the overpayment. The County of Ventura abides by the allowable actions.

The next line of prevention and detection of overpayments is the County CMIPS Payroll and is used for tracking and monitoring of overpayments. The following information is entered into fiscal data base/State CMIPS to ensure proper accountability:

1) Overpayment time period
2) Overpayment amount,
3) The name of the responsible person for repayment and
4) The agreed upon repayment option (payroll deduction, lump sum payment or payment plan

Because the State CMIPS system does not provide a monthly listing of overpayments entered or collected, researching known cases is managed by County CMIPS Payroll and is managed case by case. County CMIPS Payroll utilizes a spread sheet to track overpayments entered into CMIPS and current balances. This system allows IHSS to follow-up when providers default on their re-payment plan. Early intervention ensures program compliance.

Not all overpayments are resolved at the program level but referred directly to DHCS. Overpayments as a result of violations to Medi-Cal rules are referred directly to DHSS under Medi-Cal requirements.

IHSS Quality Assurance works under the Office of Integrity Management, a unit within the County of Ventura Human Services Agency and is a key component in the plan to identify, prevent and detect overpayments and possible fraud. The following activities are employed by IHSS Quality Assurance (QA)/CMIPS/Fiscal to increase the effectiveness of the IHSS program: 12

- <u>IHSS Quality Assurance Death Match Report (CDSS):</u>
  The Death Match Report lists providers and/or recipients using the Social Security number of deceased individuals and interfaces CMIPS information with Social Security Administration data. IHSS QA researches the IHSS case files and the State's CMIPS program for data entry errors on social security numbers, death date, and termination dates. IHSS QA consults with IHSS program staff and makes corrections as needed. If no errors are detected QA initiates the overpayment process to allow the responsible party to provide additional information to avoid overpayment, or to schedule and set up a payment plan.

- Out of State Warrants (CMIPS):
  IHSS QA researches and investigates IHSS payroll warrants issued with out-of- state addresses. Matching paid days after the termination date of the client is essential in detecting potential fraudulent activity. QA initiates the collection process as necessary.

- IHSS Quality Assurance Review of 300+ Provider Hours Report (CMIPS):
  The 300+ Report identifies providers working in excess of 300+ hours a month and automatically triggers a comprehensive case review by QA, IHSS program staff and Public Authority. The risk of overpayments, fraud and neglect in the care of IHSS recipients is substantially increased when providers claim to work an extraordinary number of hours. The case review includes interviews with IHSS clients to verify that the work is completed as prescribed in the Hourly Task Guidelines. . The process for identifying and collecting overpayments or reporting of suspected fraud is initiated by QA. In some instances a referral to Adult Protective Services may be required.

- IHSS Program– No time card within 60 Days activity (CMIPS):
  No time card activity may be an indication that the IHSS client is in the hospital or that needed services are not being rendered. Immediate action is taken to identify the cause of the time card inactivity for appropriate program response. This activity is important in fraud prevention to prevent a provider from claiming time for work not performed.

- County CMIPS Payroll: Time Card Processing Delays:
  There are many reasons time card processing is delayed such as missing signatures, hand-written time sheets and/or over claimed hours. Each of these reasons requires investigation by IHSS Program operations. Working collaboratively in a joint effort, the fiscal department of the Human Service Agency and IHSS program management track and monitor these breaches to ensure timely corrective action is taken. If fraud is suspected, the procedure for overpayment alleged fraud referral is initiated. Regardless, providers are paid timely.

Underpayments

IHSS social workers and management are notified when the provider pay warrant and authorized hours do not match. If confirmed as a legitimate underpayment, the IHSS social worker corrects the information in CMIPS and requests a supplemental time sheet for the period in question.

Activities to Ensure Accuracy in Time Card Completion

IHSS Public Authority provides ongoing orientation and training classes for registry providers and in-home orientation and training for family based providers on the rules

and regulations of the IHSS program. Time card coding requires a concentrated effort by the Public Authority to keep all providers aware of the requirements and consequences of incorrect and inconsistent time coding. Training is mandatory for all Public Authority providers and is a key element in preventing overpayments and fraud.

Reducing Overpayments and Early Detection of Possible Fraud

In addition to our current operational plan, the County of Ventura proposes these steps to reduce overpayments and to ensure early detection of possible fraud:

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1. Errors in time card coding are a major cause of overpayments and underpayments within the IHSS Program. To reduce overpayments, IHSS program operations will increase focus on outreach and education about proper and accurate time coding and increase knowledge among providers about the rules and regulations of the IHSS program, in particular, claiming hours when clients are hospitalized.

2. Most overpayments are a result of errors by the client or provider. However, an overpayment could also be an indication of fraud. Timely and accurate tracking of overpayments is essential in detecting and preventing fraudulent activity.

   The IHSS program is poised to implement the use of the Ventura Automated Collection System (VACS) to enter, track and collect overpayments. VACS is a system utilized by HSA Benefit Issuance Unit. VACS was originally designed by the County of Ventura HSA as a tracking, reporting and facilitating data base for overpayments and over-issuance collections in Food Stamps, CalWORKs, Foster Care, CAPI and General Relief programs.

   The VACS system expanded beyond the County and now includes a consortium of a number of counties. VACS is capable of providing monthly reports on overpayment initiation and recoupment and sending monthly Statement of Account to individuals indicating the amount due.

3. The IHSS Program Coordinator for CMIPS II implementation also serves as the lead for all fraud prevention and detection activities within the agency. This position has a well-established relationship with fraud investigators at the State and County level. This plan enhances these relationships and will increase the collaboration, consultation and referral process with the local District Attorney. The District Attorney's office fraud unit was part of the integration planning begun 6 months ago in April 2009 and sets the stage for increased collaboration.

Enclosure D Narrative of Data

In the past 4 years, IHSS Quality Assurance identified and reported 13 overpayments. IHSS QA fully utilizes the State SOC 824 form. Enclosure D only captures overpayments detected by IHSS QA. Of the 13 overpayments identified by County QA, it is worth mentioning that 5 were identified from the Hospital Stay Report generated by CDSS. Ventura County was a pilot County for the utilization of the Hospital Stay Report. Upon review and investigation, these cases involved providers over-claiming hours while recipients were hospitalized. The Hospital Stay report, although no longer available to IHSS programs, showed promise as a tool in detecting and preventing fraud.

IHSS utilizes several sources of information in identifying, reporting, and resolving overpayments as described above. One such report is generated by EDS. In addition to the overpayments indicated on enclosure D, 40 instances of recoupment activities from FY 04/05 to 08/09 totaling $13,075, came from the EDS report.

The following is a breakdown of FY 05/06 through 08/09 overpayment and fraud referrals that are reported on Enclosure D.

- Of the 13 cases referred for overpayment, 8 were a result of over claimed hours and time card signatures discrepancies. Both recipients and providers appear to be the responsible parties. These findings were detected by County CMIPS payroll personnel, IHSS Social Workers and QA activities.
- The remaining 5 cases were for hours being claimed on time cards on specific days when client were in a hospital. These overpayment activities are committed by providers. All of these particular findings were detected by an error rate report generated by CDSS. Again, Ventura County participated in the pilot project and found the information in the error rate of potential value.

Since FY 05/06, 21 cases were referred to DHCS Fraud Unit. Of those cases, 4 were initially identified as an overpayment, but later led to a referral for suspected fraud. The details of those cases are as follows:

- The death match report identified 5 cases where providers fraudulently claimed hours and received warrants for payment of services after the deceased date.
- An IHSS social worker and CMIPS fiscal staff identified 2 alleged provider and client fraud and referred to DHCS for further investigation.
- Monthly review of the 300+ hour report is critical to detecting and preventing fraud. IHSS referred 8 suspected fraud activities on providers claiming 400 hours worked in one month. Upon careful review, including interviews with the provider and client, these cases were highly suspect and referred to DCHS for further investigation.

- Of those cases referred to DHCS, 1 referral was subsequently referred to the County of Ventura District Attorney for prosecution. This resulted in a guilty verdict and court order restitution.

The IHSS program developed an IHSS fraud referral checklist and referral form to be used when fraud is suspected. This form was developed by the IHSS Fraud Prevention and Detection Work Group and is attached (form 56-13-4A)

Fraud Referrals/Outcomes

In consultation and collaboration with the County of Ventura District Attorney, the Human Services IHSS program has identified areas of concern in fraud detection. These include, but not inclusive, are client's misrepresentation of need, providers claiming hours not worked and fraudulent time card coding to name a few.

Detection of fraud is generated from various sources within the Human Services Agency IHSS program and is coordinated through the IHSS Program Coordinator and the IHSS Fraud Prevention and Detection Work Group. The procedure for reporting suspected fraud is the same procedure for reporting overpayment activity since overpayment activity may be an early detection of fraud or a gateway into fraudulent activity.

Fraud referrals are generated from the 4 units within the Human Services Agency that include the IHSS Public Authority, IHSS operations and social work practice, Quality Assurance desk and target reviews and home visit and County CMIPS payroll/fiscal operations. Each of these units work collaboratively within the agency as a group, to ensure that suspected cases of fraud are referred appropriately.

When dependent adult and elder abuse and neglect is suspected by any of the above service areas, a referral is generated to Adult Protective Services. If financial abuse is confirmed, Adult Protective Services works with the Rapid Response Team that includes the District Attorney Elder Abuse Unit. If in the event, the alleged perpetrator of the financial abuse is a provider, consultation with the District Attorney Fraud Unit to assess whether the abuse also constitutes fraud within IHSS would occur.

The Welfare & Institutions Code directs the Counties to refer suspected cases of fraud to DHCS Fraud Investigation Unit. Under the Enhanced Anti-Fraud Program, simultaneous referrals to both the State and the local District Attorney would occur. This is important so that the County of Ventura remains in compliance with all regulations guiding the delivery of the IHSS program. However, our plan relies on the expertise and dedication of resources from the District Attorney for immediate consultation, collaboration and response to referrals. Currently, a member of the District Attorney's Office Fraud Investigation Unit provides consultation to IHSS. Under our enhanced plan, the District Attorney's Office would become an active member of our IHSS Fraud Prevention and Detection Work Group.

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The District Attorney's Office (DAO) has a well-defined methodology for determining how referrals of fraud are managed. IHSS will rely on this expertise. The DAO maintains open and ongoing communication with DHCS Fraud Investigation Unit and a joint decision is made based on set criteria which entity would have primary jurisdiction. It would be imperative that the DAO has information from the State as to open cases, background information on previous referrals or any other information needed to investigate the referral. Coordination of efforts is part of the DAO's standing practice with the CDHS. Communication with the State serves another vital function: to eliminate the risk of duplication of efforts. In the event that the alleged fraudulent activity supersedes local or State jurisdiction, County of Ventura District Attorney will coordinate with the Federal authorities. All new regulations will be incorporated into this plan.

Collaboration and Partnerships with District Attorney's Office (DAO)

The Ventura County District Attorney's Office (DAO) and the Ventura County Human Services Agency (HSA) have enjoyed a strong working partnership for over 13 years. The DAO currently provides all investigative resources through its Government Fraud Investigation Unit for HSA for public assistance programs involving Cal Works, food stamps, cash aid etc. This includes early detection/prevention fraud investigations as well as ongoing fraud investigations and prosecutions. This model partnership would be the basis for fraud investigations and program integrity related to In-Home Support Services (IHSS).

The program currently in place provides for the HSA case workers to make referrals for investigation to the DAO. Designated investigative staff members receive these requests, and after investigation, provide information back to the case workers. More specifically, there are two parts to this program. Case workers processing new applications or renewals for benefits have the ability to request investigation into the information provided by the applicant, as well as information that may not have been provided, so that a more informed decision on granting benefits can be made.

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This information can include criminal history checks, home visits to determine household composition, financial checks etc. This information is typically obtained and provided to the case worker within a few days of the request. Our experience has been that of the requests for investigation in the early detection/prevention arena, that the information obtained and provided to the case workers have resulted in an approximately 35-40% denial rate. This shows that the additional information obtained by the investigative staff and provided to the case worker is vital for making an informed decision and in preventing fraud.

The second part of our existing program provides investigative and prosecution resources for those cases in which someone has been receiving benefit assistance and is suspected of committing fraud. Case workers obtain information from a variety of sources that cause suspicion of possible ongoing fraud. This can be for various reasons such as unreported income, change in household composition, disqualifying

felony convictions, fleeing felon matches etc. These cases are referred to the DAO investigative unit for investigation. After the investigation is complete a criminal case may be filed if warranted. All information obtained is shared with the case worker so any needed adjustment or discontinuation of benefits can be made. When criminal convictions are obtained, restitution orders are obtained from the court for the overpayment amounts.

The DAO investigative unit also provides ongoing training to HSA staff. This training includes information of how to detect possible fraud during the benefit application or renewal process, as well as during case review. This training has been very valuable in educating case workers who then refer cases of suspected fraud to the DAO for investigation.

Our plan for the Enhanced Anti-Fraud Program would add designated member(s) of the District Attorney's Office Government Fraud Investigation Unit. Specifically, a designated investigator(s) would be assigned to work directly with IHSS staff and the Program Coordinator in the detection and investigation of suspected fraud. The investigator(s) would develop an expertise in the rules and regulations applicable to the IHSS benefits system. Working directly with the IHSS staff, they would identify and implement processes that would assist in identifying and reducing fraud in the program.

Additionally, working closely with IHSS staff and the DCHS Fraud Investigation Unit, the investigator would provide timely investigative services for any referrals of suspected fraud. Using a similar process already in place for the referral and investigation of suspected public assistance benefit fraud as discussed above, the assigned investigator would work closely with IHSS staff to obtain and provide information pertinent to detecting and preventing fraud.

Some of the services the assigned investigator would provide include:

- Investigative services for Early detection/fraud prevention
- Investigate cases of suspected fraud by recipients
- Investigate cases of suspected fraud by providers
- Provide skip tracing services to locate those persons with overpayment responsibilities
- Participate in bi-monthly meetings with the Fraud Prevention Work Group
- Liaison with DCHS Fraud Investigations Unit to coordinate investigative efforts.
- Provide training to IHSS staff in the detection and identification of fraud
- Gap analysis of IHSS fraud prevention and detection activities.

Both the DAO and IHSS commit to working within all laws, regulations and mandates set forth by CDSS and CDHS in implementing the Enhanced Anti-Fraud Program.

Tracking Referrals to DHCS

As the lead for all fraud referrals, the IHSS Program Coordinator maintains a data base that is accessible by authorized members of the Fraud Prevention and Detection Work Group. This data base is password protected to ensure the integrity of the information and confidentiality. The data base includes the following information for tracking purposes: description type of fraud, amount of the alleged fraud, date sent to DHCS and date of response from DHCS, disposition, case name and comments. The database is the centralized repository for all referrals for fraud generated from a unit or worker within IHSS, Public Authority, fiscal/payroll, QA. With our ability to utilize local expertise, this data base will be expanded to include referrals to the District Attorney.

Collaboration and Partnerships with California Department of Health Care Services (DHCS) and the California Department of Social Services (CDSS)

HSA is committed to continuing its partnership and collaboration with CDSS and partner with stakeholders, such as Department of Health Care Services, California State Association of Counties, and the County Welfare Directors Association. Maintaining and enhancing relationships with County and State partners who share similar missions and goals, is vital to the success of any plan. HSA and the District Attorney's Office currently work collaboratively with DHCS and CDSS and will utilize every resource and opportunity to consult, confer and maintain open and continuing communication as needed to ensure the success of the plan and integrity of its efforts. The County of Ventura will ensure that all supporting documentation needed by CDSS and/or DHCS will be provided timely. Each fraud referral, at a minimum, will contain the following documentation:

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- Confidential Medi-Cal Compliant Report – MC 609
- Application for Social Services – SOC 295
- Provider Enrollment Form – SOC 426
- Recipient/Employer Responsibility Checklist – SOC 332
- Provider Time Sheets – SOC 361
- CMIPS information screens:
    - Recipient eligibility
    - Provider eligibility
    - Recipient Authorized Payment Summary
    - Provider Payment Summary
    - Pay warrant yearly summary
    - Pay warrant information for overpayment period

Mechanism for Tracking/Reporting
Presently, HSA is monitoring, tracking and will report out on the following data:

- Timesheet processing delays - IHSS
- No timesheet activity for 60 days - IHSS
- Death Match - QA
- Out of state warrants - QA
- Provider 300 + report - QA
- Fraud overpayment tracking - Fiscal
- VACS (track overpayment collection) – Fiscal

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The County of Ventura will track all of the activities and outcomes of this plan utilizing existing data bases and the expertise of the Office of Integrity Management, a unit within HSA that tracks, analyzes and reports all outcomes for the agency. IHSS and DAO will rely on this expertise to report out the outcomes for the Enhanced Program.

County's Current and Proposed Anti-Fraud Activities
One portal for preventing and identifying fraud is the timely and appropriate identification, tracking, monitoring and collecting of overpayments. This process is more efficient and effective as a result of the work by the IHSS Fraud Prevention and Detection Work Group.

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The strategies for anti-fraud activities are similar to those utilized for overpayments. Currently, IHSS uses an integrated approach in the detection of fraud. Suspicious activity, missing signatures, signatures that appear different than the authorized signature, home visits, conversations with recipients, providers and neighbors; data match reports, obituaries and sometimes, social worker intuition are those activities that currently identify possible fraudulent activity. Another current strategy is the ongoing relationship with DHCS Fraud Investigation Unit, District Attorney and timely and appropriate referrals of suspected fraud. Although we have a good relationship with the County of Ventura, the DHCS Fraud Investigator has such a broad regional responsibility that timely response is difficult. Partnering with the DOA will ensure more timely local response.

With the Enhanced Anti-Fraud Program, the County of Ventura can increase its awareness and activities to protect the integrity of the program and the people it serves. Essential to the plan for the County is the inclusion of the District Attorney into our Fraud Prevention and Detection Oversight Group as well as relying on the DAO expertise in the detection of fraud and the infrastructure in place with the DAO for HSA's cash aid programs.

Essential elements of our proposed anti-fraud activities include building on the expertise of the DAO that include the following:

- Investigative services for Early detection/fraud prevention
- Investigate cases of suspected fraud by recipients
- Investigate cases of suspected fraud by providers
- Provide skip tracing services to locate those persons with overpayment responsibilities
- Participate in bi-monthly meetings with the Fraud Prevention Work Group
- Liaison with DCHS Fraud Investigations Unit to coordinate investigative efforts.
- Provide training to IHSS staff in the detection and identification of fraud
- Gap analysis of IHSS current fraud prevention and detection activities
- Appropriate tracking, monitoring of activities and referrals and outcomes. HSA has an internal team called the Office of Strategic Management who provide assistance in the collecting and analyzing of data. This plan would call upon their expertise.

Staffing Plan

Current Staffing Plan for Fraud Prevention and Detection:

1 DHCS Fraud Investigator (regional coverage including portions of LA)

1 Quality Assurance Social Worker

1 CMIPS/Payroll/Fiscal

Fraud Prevention and Detection Work Group comprised of Supervisors and Managers for IHSS, Public Authority, Fiscal, QA, Benefit Issuance and Executive Management

Proposed Staffing Plan for the Enhanced Anti-Fraud Program:

1 or more DHCS Fraud Investigator (pending new regulations)

1 County of Ventura District Attorney Fraud Investigators

1 Quality Assurance Social Worker

1 CMIPS/Payroll/Fiscal

1 IHSS Social Worker designated to fraud prevention and detection

The Fraud Prevention and Detection Oversight Group (not funded)

County Proposed Budget for Utilization of Funds

Position/Activity	Mo. Cost per 1 FTE (S+B+OH)	Current Budget			Proposed Budget			Planned Increase
		# of FTEs	# of Activity Months	Annual Costs	# of FTEs	# of Activity Months	Annual Costs	
DHS Fraud Investigator	N/A	1	12	$0	1	12	$0	$0
Quality Assurance Social Worker	$10,314	1	12	$123,768	1	12	$123,768	$0
Combined CMIPS Payroll / Fiscal	$7,875	1	12	$94,500	1	12	$94,500	$0
County District Attorney Fraud Investigator	$18,334	0	0	$0	1	8	$146,672	$146,672
IHSS Fraud Prevention/Detection Social Worker	$10,314	0	0	$0	1	8	$82,512	$82,512
	TOTALS	3		$218,268	5		**$447,452**	**$229,184**

Integration of Other Program Integrity Efforts within the Plan

HSA will abide by and will uphold any and all regulation and legislative changes which will soon be disseminated by CDSS via All County Letters. Recent changes in regulations support HSA continued process improvement activities.

The County of Ventura Public Authority for IHSS has been conducting Provider Orientation since 2003 in groups and in the home of the recipient. These are mandatory for Registry providers prior to working for IHSS. The training is comprehensive lasting for 5 days. The orientations focus on the SOC 332, SOC 426 monitoring provider's time and how to complete time cards. The orientation covers a majority of the material which will be required by CDSS effective November 1, 2009. IHSS-PA requires Live-Scan of their registry providers since April, 2007. Upon request, the Public Authority provides background checks for family based providers at no charge to the family. 19

With changes to the requirements coming soon, all standing and any future PA providers would be required to be Live Scanned. It is the intention of IHSS and IHSS/PA to comply with all new requirements for fraud prevention and detection.

An annual plan for Quality Assurance activities is submitted as required to CDSS. In a recent QA review by CDSS, our plan was in compliance and we met our goals.

IHSS and DAO will integrate the anti-fraud activities into a successful and well-established protocol within HSA to prevent, detect, investigate and prosecute fraud in

the cash aid programs of Food Stamps, CalWORKs, Foster Care, CAPI and General Relief.

This proposed plan arises from the success of years of collaboration with CDSS, CDHS and the relationship between the County of Ventura Human Services Agency.

Annual Outcomes Report

HSA and the DAO will collaborate and provide annual outcomes on the format to be provided by CDSS. The Enhanced Anti-Fraud Program will ensure that current efforts to prevent and detect fraud will not only continue but will improve in its effectiveness to maintain the integrity of the IHSS Program. Examples of outcomes to be tracked would include the number of cases referred to the DAO, the percentage resulting in prosecution, the activities implemented by IHSS as a result of the DAO gap analysis, types of fraudulent activity.

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Enclosure D

County: Ventura

Overpayments identified by County QA		04/05	05/06	06/07	07/08	08/09
Total Amount per Fiscal Year:						
Number of Instances:			1	1	6	5
Breakdown of Causes	Provider:		1	1	3	2
	Recipient:				3	1
	County Error:					1
	Unknown:					1
	Other:					

Underpayments identified by County QA		04/05	05/06	06/07	07/08	08/09
Total Amount per Fiscal Year:						
Number of Instances:				1		
Breakdown of Causes	Provider:					
	Recipient:					
	County Error:					
	Unknown:			1		
	Other:					

Fraud Referrals/Outcomes		04/05	05/06	06/07	07/08	08/09
Number of referrals to DHCS:			1	1	3	16
Number handled locally by DA:			1		1	
Number of convictions:					1	
Court Ordered Restitution:					1	
Amount of funds involved in the convictions:					6818.75	
Amount of funds recovered:						
Amount of funds pending recovery:						
Basis for the Conviction:						
Individuals Responsible	Recipient:					
	Provider:				3	15
	County Staff:					
	Other:					1
	Unknown:					

Enclosure D
Page Two

Utilization of County DA for Fraud		04/05	05/06	06/07	07/08	08/09
Documented referrals to DA*			1			
Outcomes	Accepted:					
	Rejected:					
	Pending:					
	Completed Investigation					
	No Fraud:					
	Restitution Action:					
	Referred for Prosecution:					
	Criminal Charges Filed:					
	No Charged Filed:					
	Convictions:					
	Acquittals:					
	Dismissals:					
	Pending Investigation:					
	Restitution					
	Court Ordered:					
	Restitution Action:					
	Fines					
	Prosecutions Completed					
	Convictions					
	Misdemeanor					
	Felony					

Budget Justification
Ventura County's Fraud Funding Plan for FY 2009-10

Budget Section	Total
A. Personnel Costs (includes employee benefits)	$ 180,445
B. Operating Expenses	$ 10,000
C. Equipment Expenses	$ 2,400
D. Travel/Per Diem and Training	$ 1,150
E. Subcontracts and Consultants	$
F. Other Costs	$ 2,618
G. Indirect Expenses	$ 32,570
Total Expenses	$ 229,183

A. Personnel Costs (including employee benefits)	Total Budget
Title: District Attorney Investigator I @ 1.0FTE **Salary Calculation:** FY Salary ($48,506) + Benefits ($34,599) **Duties Description:** Investigative services for Early detection/fraud prevention; Investigates cases of suspected fraud by recipients; Investigates cases of suspected fraud by providers; Provides skip tracing services to locate those persons with overpayment responsibilities; Participates in bi-monthly meetings with the Fraud Prevention Work Group; Liasion with DCHS Fraud Investigations Unit to coordinate investigative efforts; Provide training to IHSS staff in the detection and identification of fraud; Gap analysis of IHSS fraud prevention and detection activities.	$ 83,105
Title: Senior Investigator @ .30 FTE **Salary Calculation:** FY Salary ($18,784) + Benefits ($13,070) **Duties Description:** Ovesight of the Investigative services for Early detection/fraud prevention; Investigates cases of suspected fraud by recipients; Investigates cases of suspected fraud by providers; Provides skip tracing services to locate those persons with overpayment responsibilities; Participates in bi-monthly meetings with the Fraud Prevention Work Group; Liasion with DCHS Fraud Investigations Unit to coordinate investigative efforts; Provide training to IHSS staff in the detection and identification of fraud; Gap analysis of IHSS fraud prevention and detection activities.	$ 31,854
Title: IHSS Social Worker @.5 FTE **Salary Calculation:** Salary ($50,286)+ benefits ($25,200) **Duties Description:** Provide investigative services for Early detection/fraud prevention; investigate cases of suspected fruad by recipients/providers.	$ 75,486
Title: **Salary Calculation:** **Duties Description:**	$
Title: **Salary Calculation:**	$

Duties Description:	
Title: Salary Calculation: Duties Description:	$
Total Personnel Costs:	$

B. Operating Expenses	Total Budget
Title: Vehicle Usage and other office supplies Description:	$ 10000
Title: Description:	$
Title: Description:	$
Total Operating Expenses:	$

C. Equipment Expenses	Total Budget
Title: Computer Purchase Description: Desktop, monitor, printer and software	$ 2400
Title: Description:	$
Title: Description:	$
Total Equipment Expenses:	$

D. Travel/Per Diem and Training	Total Budget
Title: Site Visits to Sacramento and Fresno Counties Description: Airfare @ $165 x 2 employees = $330; Hotel @ $175 x 2 nights = $350; Meals @ $45 x 2 employees x 3 days = $270; and Parking/Ground Transportation @ $200	$ 1150
Title: Description:	$

Title: **Description:**	$
Total Travel/Per Diem and Training:	$

E. Subcontracts and Consultants	**Total Budget**
Title: **Description:**	$
Title: **Description:**	$
Title: **Description:**	$
Total Subcontracts and Consultants:	$

F. Other Costs	**Total Budget**
Title: **Description:**	$
Title: **Description:**	$
Title: **Description:**	$
Title: **Description:**	$
Title: **Description:**	$
Total Other Costs:	$

G. Indirect Expenses	**Total Budget**
Title: Personnel Costs Overhead	$ 32,570

Description: Other overhead Indirect Costs	
Title: **Description:**	$
Total Other Costs:	$